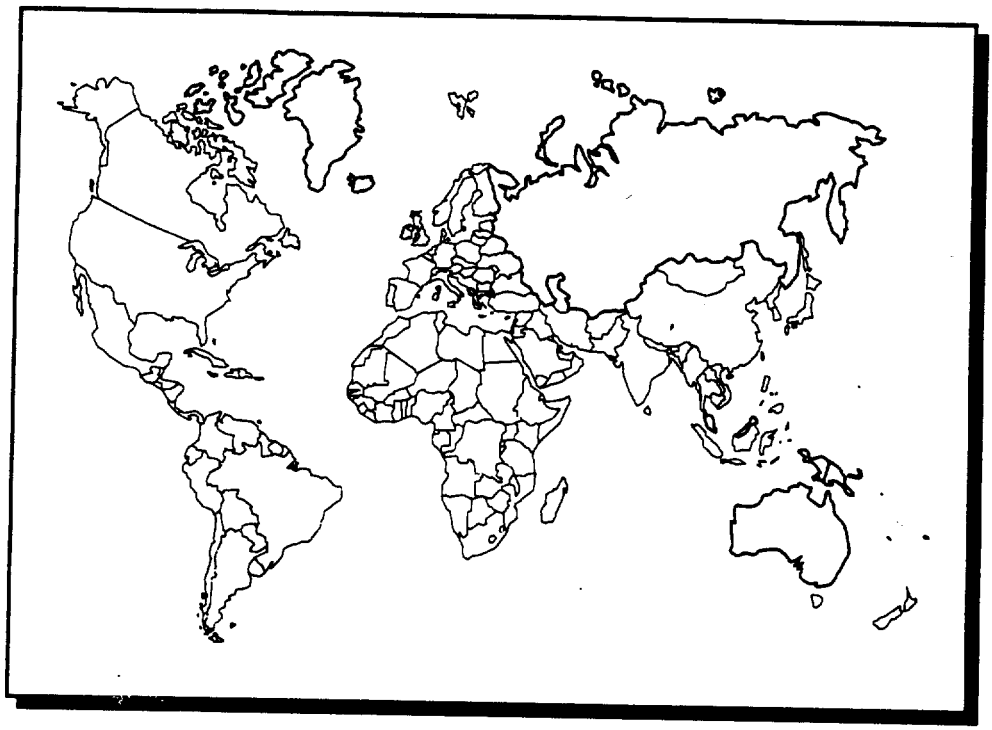
HIV/AIDS POLICY GUIDANCE

USAID



USAID

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EXECUTIVE SUMMARY

Through development assistance, research and policy formulation, the United States has played -- and will continue to play -- a leadership role in the global HIV effort.

Just as the AIDS pandemic spreads across our nation, it also continues to claim victims in all other regions of the world. In fact, it is estimated that upwards of 95% of all HIV infected people live outside the United States. As of early 1995 approximately seventeen million people, including one million children, have been infected with HIV.

-- With less than 10% of the world's population, sub-Saharan Africa accounts for about 62% of the total estimated HIV infections. Up to 30% of urban adults in Malawi, Zambia, Botswana, Rwanda, and Uganda are infected.

-- HIV infection is also quickly becoming established in other geographic areas such as parts of Latin America and Asia. The growth of the epidemic is particularly dramatic in Asia. In 1993, for the first time, Southeast Asia had more cases of AIDS than North America and almost twice as many as Western Europe.

After two decades of improvement in children's health in the developing world, infant and child mortality rates are rising in many countries as a result of HIV/AIDS.

-- By the year 2000 infant mortality is projected to increase by 35 percent in the Honduran city of San Pedro Sula.

-- Child mortality in Zambia and Zimbabwe will almost triple during the next 15 years unless there is a sharp drop in HIV infections.

-- Life expectancy at birth is declining for the first time in decades in many countries with advanced HIV/AIDS epidemics. In Uganda, AIDS is responsible for dropping life expectancy to 37 years -- the lowest in the world.

-- In the next 15 years, life expectancy will decline by more than 25 years in a number of hard hit Asian and African countries.

USAID bases its strategy for addressing the HIV/AIDS pandemic on certain key

principles and lessons learned over the past several years. Among the most important are the recognition that:

-- the battle against AIDS must address racism, sexism and homophobia. As leaders we must fight to protect the rights of people living with HIV and AIDS while we fight against the virus that is killing them.

-- AIDS is not just a health issue. The epidemic and its spread have social, economic, developmental, legal and political implications. Efforts to control the epidemic must take into consideration these issues.

To fight the global AIDS pandemic USAID will focus its strategy in three areas:

-- **HIV/AIDS prevention programs which use proven interventions to prevent transmission.** These include promoting safer sexual behavior through information, education and communication (IEC); increasing demand for, access to, and correct and consistent use of condoms; and controlling sexually transmitted infections (STIs) by improving STI diagnosis and treatment services, together with education of persons with STIs.

* These interventions have been proven successful, and implementation feasible, even in the face of difficult socio-cultural conditions. In Kenya, for example, it is estimated that USAID-supported condom interventions have prevented 110,000 HIV infections and close to 1.3 million STIs.

-- **Policy reform addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other STIs.** Key areas of policy dialogue include encouraging multi-sectoral, coordinated responses to HIV/AIDS at the senior policy levels within governments, addressing resource issues and long term sustainability at all levels, and focusing on social and cultural impediments to successful implementation of HIV/AIDS programs, including the stigmatization of those individuals infected and at risk, such as women, young adults and homosexuals.

-- **Development and testing of new interventions and methods to prevent transmission and mitigate the impact of the epidemic.** More effective interventions must be developed to adequately prevent and control this epidemic. USAID intends to pursue research activities that immediately and directly influence the effectiveness of existing programs, activities that enable women to reduce the risk of HIV infection, pilot projects and research to mitigate the impact of HIV in severely affected areas, and activities that support the public health infrastructure

and utilization of HIV vaccines.

USAID will work closely with a number of partners to implement this strategy, including:

- **Communities** - A community-owned, community-based approach is particularly relevant to HIV/AIDS prevention and is an integral strategic focus of this policy. USAID actively seeks the participation of communities and groups, including persons infected and affected by HIV/AIDS, in the design, management, implementation and evaluation of programs and policies. USAID also supports the transfer of management and technical skills to local communities, and linkages between the U.S. domestic PVO/NGO community and indigenous groups.

- **Country Programs** - Given serious resource limitations, USAID will concentrate bilateral and core resources on a limited number of emphasis countries while maintaining more modest programs in others. Emphasis countries have been identified based on epidemiologic, demographic and social indicators demonstrating that they are key contributors to the global epidemic, play a significant role in terms of geographic regional transmission, or have a high prevalence of HIV infection.

- **Regional Programs** - Experience has demonstrated that certain countries and regions are "areas of affinity;" i.e., they share characteristics that affect the spread of HIV and positively or negatively influence prevention efforts. Using this transnational approach where appropriate to implement programs and activities is both cost effective and encourages inter-regional collaboration.

- **Multilateral and other donors** - USAID is the lead donor in this sector, making close donor coordination particularly important. Also USAID will collaborate and support the efforts of the UN multilateral organizations through the new UNAIDS Programme. USAID will also continue to work closely with other bilateral donors such as Japan.

USAID HIV/AIDS POLICY GUIDANCE

I. INTRODUCTION

We are now entering the second decade of the global epidemic of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). No region of the world has been spared. The epidemic continues to exact an enormous toll in human suffering and threatens the economic, social, and political stability of many societies around the world. Particularly hard hit are the fragile health care and social service delivery systems of developing countries in which demands are great and available resources are easily overwhelmed.

In April 1987, in recognition of the threat to human life and the potential for a broad development impact of the HIV/AIDS pandemic, the U. S. Agency for International Development (USAID) drafted its first comprehensive Policy Guidance on HIV/AIDS. Now, with eight years of experience in over 40 countries, USAID has reviewed and refined the policy.

This document replaces earlier guidance and reaffirms USAID's strong and continuing commitment to provide assistance that will help developing countries address the challenges posed by the HIV/AIDS pandemic. It focuses specifically on guidelines for HIV/AIDS activities within the broader context of USAID strategic goals related to sustainable development.

II. STATUS OF THE EPIDEMIC

Estimates prepared by the World Health Organization Global Programme on AIDS (WHO/GPA) indicate that by early 1995 approximately seventeen million people, including one million children, have been infected with HIV (the virus that causes AIDS). Conservative estimates also indicate that between 30 and 40 million people will be infected with HIV by the year 2000. Current evidence shows that most, if not all, persons who are infected with HIV will eventually develop AIDS and die. Sexual transmission of HIV accounts for over 85% of the cumulative adult HIV infections in the world. Although in some settings homosexual transmission plays a significant role in the spread of HIV, heterosexual transmission is increasingly important and in many developing countries accounts for over 80% of sexual transmission. (See Appendix I for discussion of other modes of transmission).

Distinct patterns in the levels and modes of infection have emerged through examination of the geographic spread of HIV infections around the world:

- With less than 10% of the world's population, sub-Saharan Africa accounts for about 62% of the total number of estimated HIV infections.

- In some countries in East, Central, and Southern Africa, the prevalence of infection has reached critically high levels -- up to 30% of urban adults in Malawi, Zambia, Botswana, Rwanda, and Uganda.

- HIV infection is quickly becoming established in other geographic areas, such as parts of Latin America and Asia -- data from antenatal clinic attenders, considered representative of the general adult community, has found HIV seroprevalence rates of 1% to 4% among clients in urban Honduras, India, and Thailand. Much higher prevalence rates have been found among subpopulations who are engaged in high risk activities, such as commercial sex workers and patients at sexually transmitted infection (STI) clinics.

- The growth of the epidemic is particularly dramatic in Asia. In 1993, for the first time, Southeast Asia had more cases of AIDS than North America and almost twice as many as Western Europe.

Women are particularly vulnerable to the disease. Forty percent of infected adults today are women; this proportion is increasing rapidly, and the total number of infected women is expected to surpass the number of infected men by the year 2000. Over 7 million women are infected world-wide with HIV/AIDS, eighty percent of whom are in sub-Saharan Africa. This toll will reach 13 million by the year 2000. Infections among women, in turn, has an effect on children, as infants contract HIV from their mothers during pregnancy or delivery. Children are additionally vulnerable as a consequence of the loss of parents and family members to AIDS. AIDS orphans are a growing reality around the world, and are further victimized by prostitution and violence.

This scenario is compounded by the fact that, in the near future, prospects are poor for the development of preventive vaccines or therapeutic agents that would cure AIDS. In addition, access to drugs that might prolong the lives of HIV infected persons in developing countries is limited by high costs and the necessity for intensive medical monitoring, which is generally unavailable and prohibitively expensive. Provision of such services would come at the expense of other, far more cost-effective life saving interventions.

Given the nature of the epidemic and its effect on the developing world, the

demands for assistance are enormous and far exceed available resources. WHO now estimates that it would cost between $1.5 and $2.9 billion dollars per year to provide adequate support for global HIV/AIDS and STI prevention efforts in the developing world. Currently, less than $250 million is expended annually in the developing world on HIV prevention. USAID contributes nearly 50% of this total.

III. THE RATIONALE FOR USAID SUPPORT TO HIV/AIDS PREVENTION AND CONTROL

The AIDS epidemic poses a particular threat to developing countries which are already grappling with heavy debt burdens, high poverty levels, food insecurity and limited government resources. Unlike the other major communicable diseases (malaria, measles, infectious diarrheas, pneumonia, etc.), AIDS increases morbidity and deaths primarily among young adults between the ages of 14 and 49, ages normally devoted to working and childbearing. This generates periods of prolonged and severe debilitation and excessive population losses in the most economically productive age range in the population. These losses reverberate throughout societies, with negative impacts on social, economic and political structures, contributing to an environment in which broad-based economic growth and sustainable development become increasingly difficult to attain.

The epidemiology of HIV/AIDS also demonstrates an increasing effect on women and children, key target groups for the Agency. The rate of new HIV infections is growing faster in women than in men; nearly 55 percent of new infections in Sub-Saharan Africa are among women. This in turn affects children as HIV/AIDS threatens to reverse the results of years of successful investments in child survival.

In fact, many of the development gains made within the last decade could be wiped out as a result of the pandemic, both in the public health sector and within the broader economy. Evidence indicates that the epidemic is likely to adversely affect society and the human resource base in the following major areas:

Health Sector:

Clearly, the health of the population is and will continue to be severely affected, with major impact on health services systems. Improvements generated in infant and child mortality rates in the past two decades have begun to plateau and may actually be eroding in a number of African countries as a result of HIV/AIDS. For example, in Malawi, the infant mortality rate has gone from 150 to 167 deaths per 1000 live births during the past three years, and the child mortality rate from

220 to 250. This increase is ascribed to the impact of HIV/AIDS infections transmitted from mother to child. Evidence indicates that by the year 2010, AIDS could contribute to a nearly fivefold increase in childhood mortality rates in Thailand, threefold in Zambia and Zimbabwe, and double in Kenya and Uganda.

Increased demands on health budgets and social service delivery systems (including personnel, hospital beds, drugs, etc.) result from HIV/AIDS and associated opportunistic infections. Some Sub-Saharan African countries currently spend one-quarter to one-half of their health care budgets on AIDS-related care, with studies indicating that this could rise to as much as 80 percent in parts of Africa and Asia by the year 2010. As demands on the health care system increase, some countries are responding by restricting access to care for those with HIV related illness, and persons with HIV disease are sent home to die with minimal or no health care support. The drain on health services has considerable repercussions on resources available for maternal and child health, family planning, and other strategically critical services.

In addition, the HIV/AIDS epidemic has contributed to the emergence of a major secondary epidemic of tuberculosis, placing another health burden on both individuals and health care systems. Tuberculosis is affecting both HIV infected persons and, because of increased transmission, persons who are not infected with the AIDS virus. In countries in east Africa and in Thailand where the HIV epidemic is well established, the number of reported TB cases has doubled in the past three years.

Families and Households:

Recent studies have analyzed the coping mechanisms of families who have experienced deaths of adult members. They show profound consequences among households which have family members with HIV/AIDS related illness. In the most severely affected countries of Asia and east Africa, 30 to 50 percent of household income is devoted to their care and support. Combined with the loss of earnings from sick individuals, nearly 75% of the family annual income is lost due to HIV/AIDS. With subsequent loss of another adult and one child from HIV related disease, an increasingly common pattern, 100 to 165% of household income is expended, driving families into debt. Broad-based economic growth becomes impossible in such settings.

Family structure is affected, particularly with an increase in the number of orphans. In Uganda, the ability of the extended family to care for orphans is exhausted within three years of a significant number of adult AIDS deaths.

Ultimately the household's ability to cope with adverse conditions such as drought, is destroyed, resulting in reduced food security. Life expectancy is severely impacted, with projections for some countries, such as Thailand, Zimbabwe and Zambia, showing AIDS reducing life expectancy at birth by more than 25 years by the year 2010.

Community:

The social and economic impact at the household level extends to the community. Increased household expenditures and reduced savings and investment have enormous negative consequences on the resources of the community. The education sector suffers because of decreased investment in education and reduced educational performance as children are required to help at home. Community resources are drained caring for orphans and the elderly. Community level leadership, community norms, agricultural productivity and maintenance of community service projects, such as potable water supplies, are also severely affected by the epidemic.

Agricultural sector:

In severely affected countries, broad movement toward less labor intensive crops and crop production technologies, with resultant lower yields and reductions in marketed output, are being observed. This may have implications for food security at the national level. USAID is now undertaking studies, in cooperation with the U.S. Department of Agriculture, to better define this impact.

Industrial sector:

In east Africa, negative effects have been documented on specific segments of the "modern" labor sector, i.e. enterprises that employ greater than ten staff. Mining, trucking/transportation, and services are the most severely affected sectors. It is likely that the epidemic will result in increased production costs due to increased morbidity in the workforce, decreased productivity, loss of skilled and trained workers, and increased employer-funded medical costs. Negative effects are also being observed on the quantity and quality of the labor supply and on investment decisions, including investment in human capital.

Security/Military Sectors:

High rates of HIV infection among police and military personnel could threaten internal and national security. In some countries in Africa and Asia, 15 to 40% of

military recruits are HIV positive. Spouses and "camp-followers" are, therefore, at dramatically increased risk. While the U.S. Government supports demobilization of military forces in developing countries, this could further exacerbate the HIV/AIDS epidemic as HIV positive military personnel return to their villages and homes and transmit HIV.

Macroeconomy:

In multiple socio-economic impact studies, a number of these factors combine to impact negatively on the macroeconomy. The impacts include aggregated negative impacts at the household and sectoral levels, decreases in overall domestic savings and investment levels, negative effects on foreign investments, reductions in the volumes of imports and exports, and reduction in receipts from tourism. Classic macroeconomic indicators, such as gross national product (GNP) and gross domestic product (GDP) per capita, may not be sensitive enough to accurately measure this impact. New tools are needed to assess the impact of HIV/AIDS at the macroeconomic level. USAID-supported studies by the World Bank are now underway to assess the spectrum of potential monitoring methods.

Political Environment:

Because of the issues identified above, HIV/AIDS has a high potential to contribute to political instability, particularly in countries with emerging democracies. The irreversible loss of educated leaders is an increasing possibility, and is already being seen in countries in east Africa.

Clearly, HIV/AIDS has both actual and potential impacts on women, men and children, individuals and populations, and the movement towards sustainable development in countries and regions. It also has a negative effect on previous USAID investments and development successes achieved to date. The cross-cutting nature of the epidemic is evident in the numerous areas in which it impinges on USAID objectives: protecting human health; encouraging broad-based economic growth; building democracies; empowering women; and providing humanitarian assistance.

Development activities also have the potential to inadvertently facilitate the spread of the disease. For example, construction projects create primarily male migrant work camps which often foster increased commercial sex. Road and transportation projects provide ready routes of transmission, and new towns along these routes often serve as crucibles for transmission. As in the environment sector, the effect of development activities on HIV needs to be carefully considered in the formulation of USAID strategies, objectives, programs, projects and evaluation systems. Anticipation and mitigation of

significant negative impacts on HIV must be a part of strategic planning for such infrastructure projects.

In sum, given the broad and compelling implications of the HIV/AIDS pandemic on the people of the developing world, and its potential impact on micro and macro development, USAID will sustain a strong commitment to HIV/AIDS programs.

IV. LESSONS LEARNED

As the epidemic has progressed, knowledge and experience with the disease have provided valuable lessons. USAID has developed increasingly effective targeting and implementation mechanisms through its work in the area of HIV/AIDS for the past eight years.

There have been notable accomplishments. Program interventions have been proven successful, and implementation feasible, even in the face of difficult socio-cultural conditions. The Agency has been able to demonstrate and measure results and impact.

- In Kenya, USAID has supported interventions to increase condom use. Newly developed models estimate that 110,000 HIV infections and close to 1.3 million STIs have been averted due to the consequent increase in condom use.

- In Haiti, condom sales rose from approximately 600 thousand in 1991 to 4 million in 1992 in response to USAID's targeted communications and motivation effort in spite of political upheaval.

- In Brazil, policy reform activities supported by USAID focused on working with local advocates to lobby for the repeal of the 15 percent import tax on condoms. Analysis showed that the tax made the product too expensive for most people who needed it and helped convince policymakers that a supply of affordable condoms was crucial to slowing the spread of HIV/AIDS in Brazil. The tax was withdrawn in April 1994.

- In the Dominican Republic, USAID-supported policy work contributed to the passage of legislation outlawing discrimination against people with HIV/AIDS and mandating that every government ministry have a plan to address the epidemic.

- Thailand, supported by USAID assistance, has implemented an effective prevention program that serves as a model for other Asian countries. One important and innovative policy instituted by the Thai government and supported

by Thai business interests is the "100 percent condom" policy, which requires 100 percent condom use in brothels.

- With USAID support, significant progress has been made toward the discovery of an effective vaginal microbicide. A promising compound derived from natural sources has been shown to inhibit transfer of HIV from infected lymphocytes to vaginal cells. Phase One field trials are now beginning in Thailand.

Based on Agency experience, several key lessons have emerged as critical to achieving success in preventing the spread of the disease. They constitute the major factors behind USAID's areas of intervention. Broadly, these fall into three categories:

- Identifying socio-economic and cultural determinants that place individuals and communities at risk of infection;

- Identifying individuals/populations who engage in behavior or are associated with someone who engages in behavior that puts them at particularly high risk of becoming infected or transmitting HIV; and

- Designing effective responses to reduce risk and transmission.

A. Factors That Increase the Vulnerability of Persons:

Women are at greater risk of HIV infection than men, due in part to the higher biologic efficiency of sexual transmission from men to women, and to the sexual vulnerability related to low socio-economic status of women in many countries of the world. This is particularly true for young women and girls between the ages of 14 and 20. Low status can affect women's knowledge of and ability to adopt practices to protect themselves from HIV. In situations where men have greater access to economic resources, and social-religious and legal conventions maintain gender inequities, women may have little or no say concerning their sexual relations with men. Women and girls with limited education are also less able or likely to respond to information about the disease and take preventive measures.

HIV programs which address women not only prevent infection in women themselves but also in their infants. Tools to prevent STIs and HIV such as female controlled barrier methods, better access to information from family planning and reproductive health settings, and communication skills to better negotiate sexual relationships, all serve to empower women and thus contribute to preventing the spread of the disease.

Youth represent a unique set of challenges, as the combination of their biological, emotional, economic and legal situations make them particularly vulnerable to HIV transmission. WHO estimates that half the people infected with HIV acquired it between the ages of 15 and 24. To prevent infection in this population USAID supports efforts using messages, channels and methods specific to youth. The intervention opportunities for young adults range from peer counseling, and education and vocational skills building, to legislative efforts related to youth. Prevention strategies, especially for youth, should include opportunities to build so-called "life skills" in communication, decision making, negotiation, and abstinence.

Urbanization and Migration draw persons and populations from their rural communities and place them at increased risk of HIV infection. Individuals separated from family and traditional values can be affected by drastic changes in socio-economic and cultural influences. The epicenters of the HIV epidemic have been found to follow migrant labor flows, suggesting that high risk behavior may be associated with displaced communities. Additionally, involuntary migration in response to civil war or disasters increases the vulnerability of communities to HIV infection. There are, however, potential dangers in focusing on the movements of persons and populations as part of HIV prevention efforts. It could lead to discrimination against certain groups and the creation of inappropriate and counterproductive immigration screening regulations. Therefore, more enlightened methods need to be developed to intervene with "travellers" that do not lead to stigmatization but that arm them with the knowledge and tools to protect themselves and their partners.

Sexually Transmitted Infections significantly increase the efficiency of HIV transmission. Therefore, improving STI services and providing education for people with sexually transmitted infections are the logical focus of prevention efforts. The presence of an STI, particularly one that causes genital ulcers (syphilis, chancroid), increases the likelihood of sexual transmission of HIV by 5 to 20 times. In addition, persons with recurrent STIs are effective targets for communication campaigns to induce behavior change because they are more likely to be engaging in frequent casual high risk sexual encounters. Educational campaigns that focus on STI patients have been shown to have up to eight times as large a preventive impact as those aimed at the general adult population. Recent data from Tanzania demonstrated a 40% reduction in incidence of new HIV infections among communities in which an effective STI intervention program was being conducted.

USAID recognizes that individuals who are marginalized by society (including

commercial sex workers, intravenous drug users, men who have sex with men, and prisoners) are crucial participants in HIV/AIDS prevention interventions. USAID will work with these marginalized populations in order to be effective in reducing the spread of HIV.

B. Responses to reduce risk and transmission

Sustained behavior change is required to limit sexual transmission. This is a complex and difficult task. Success in HIV/AIDS prevention is predicated upon the ability to effectively influence sexual behaviors. The only prevention interventions currently available are: adoption of safer sexual practices including delaying the onset of sexual activity; sexual abstinence; decreasing the number of casual sexual partners; maintaining faithful monogamous or culturally appropriate stable polygamous relationships; and, consistent, correct condom use. Other critical steps include assessment by the individual of his/her own risk and motivation to practice safer sex. Cultural traditions or practices and political and religious views may impede or support the adoption of specific behaviors.

AIDS education and communication programs have been shown to help modify behavior. Multiple reinforcing channels of communication aimed at changing knowledge and attitudes toward safer sexual behavior are preludes to behavior modification. The identification and adoption of safer sexual practices as a social norm contribute to sustained behavior change. Programs conducted at the sub-national level involving specific communities or groups engaged in high risk behavior have proven most successful.

Condoms are effective in preventing the spread of STIs and HIV. Increasing the demand for, access to, and consistent and correct use of condoms are key factors in reducing the transmission of HIV infection.

Improving STI services by facilitating access to and improving quality of services, and facilitating access to STI drugs, are efficient and effective ways to address the spread of HIV. In addition to primary prevention activities, interventions that improve the demand for and quality of public and private sector clinical services are important. Accurate diagnosis and effective treatment of STIs limit the infectivity and duration of active STI infections, and the consequent risk of HIV.

Community participation, including persons infected and affected by HIV/AIDS, in the design, development, implementation and evaluation of HIV prevention policies and program activities assures that programs are relevant and supports sustained behavior change in target populations. Community involvement is also

critical for the long-term sustainability of programs. Community "ownership" contributes to the likelihood that activities will continue following the period of donor support.

V. STRATEGY

USAID's overall mission is the promotion of sustainable development for lasting improvement of the human condition. The basic strategic goals which must be addressed in order to carry out this mission are:

* Stabilizing global population and protecting human health;
* Encouraging broad-based economic growth;
* Building democracy;
* Protecting the environment; and
* Saving lives, reducing suffering, and reinforcing development potential.

As discussed earlier, the HIV/AIDS epidemic has direct negative consequences on the first two goals, and very probable consequences on the third. Therefore, HIV/AIDS needs to be considered as an integral part of any broad strategy for sustainable development.

Within the strategic goal of stabilizing global population and protecting human health, four agency-wide strategic objectives have been identified which contribute to **both** fertility and health outcomes:

The reduction of unintended pregnancies;

The reduction of sexually transmitted infections

The reduction of maternal mortality: and

The reduction of child mortality.

Reducing transmission of HIV/AIDS, the most deadly and rapidly spreading of sexually transmitted infections, is the key component of the second objective. HIV/AIDS is becoming an increasingly important contributor to the number of child and maternal deaths in many African countries as well. As such, HIV/AIDS prevention fits squarely within the agency's strategy for this sector.

The guidance provided by this document is intended to be flexible, building on the lessons learned and enabling USAID to respond quickly to incorporate new advances in HIV/AIDS prevention and control measures as they develop. It considers areas in which USAID has a comparative advantage, particularly relative to technical leadership, field presence and support, and linkages both within the PHN sector and across other USAID areas of intervention. In order to remain relevant and useful, this guidance will be reviewed and revised periodically.

As noted in the previous sections of this document, the challenges posed by the HIV/AIDS pandemic are almost limitless and could readily consume more than the entire development budget of the Agency. ***Since the Agency's fundamental mission is directed toward long-term sustainable development rather than short-term relief, and since resources are limited, the strategic basis for this HIV/AIDS policy is directed toward minimizing the total number of HIV/AIDS cases in the world by the year 2025.***

Priority will be placed on interventions and areas that are most likely to ultimately decrease the number of persons infected by HIV and, thus, to decrease the severity of the global epidemic and its impact on sustainable development. To achieve this, particularly given limited resources, USAID will need to focus efforts, and undertake a more proactive and aggressive approach to policy reform, leveraging of other donor resources, and more effective donor coordination.

This has several implications. First, it means that the primary focus of USAID supported activities will be on prevention of new HIV infections, rather than on the treatment of existing HIV infections. In many circumstances, however, care for affected populations will make prevention efforts more effective in cost and impact. In these cases, USAID will consider strategies that encompass the provision of care for affected individuals and communities as an important tool for long-term prevention.

Given this context USAID will direct efforts in the following three areas:

A. HIV/AIDS prevention programs using proven interventions to prevent transmission.

B. Policy reform addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other STIs.

C. Development and testing of new interventions and methods to prevent transmission and mitigate the impact of the epidemic.

To maximize the use of available resources, and achieve impact on the global

epidemic, USAID will also concentrate efforts by supporting comprehensive approaches in a number of countries, identified as those most critical for controlling the global pandemic. (See Appendix II for HIV/AIDS emphasis country list.) It should be noted that even in these countries, USAID may not have the resources required to mount nationwide efforts. More limited efforts will be supported in other countries, as appropriate. In addition USAID will provide continued support for coordinated multilateral efforts.

In addition to focused HIV/AIDS/STI prevention projects, prevention activities will be increasingly integrated with other USAID sustainable development efforts. In the health and population sector this will be in the context of integrated reproductive health approaches. Other priority sectors for the Agency are also ripe with opportunity to incorporate certain HIV/AIDS interventions, particularly in the economic growth and education sectors. Examples include incorporating HIV/AIDS prevention information in school curricula and microenterprise programs targeted to women.

A. HIV/AIDS prevention programs that utilize proven interventions to prevent transmission.

USAID resources are used for the implementation of prevention activities at the regional, country and community level, with a particular focus placed on comprehensive programs in emphasis countries.

The interventions utilized in USAID's HIV/AIDS prevention activities have been developed based on clear epidemiological trends, findings of behavioral, biomedical, and operations research, and knowledge gained from successful behavior-change interventions conducted to date. They focus on preventing sexual transmission and are known to be effective, including the participation of HIV positive individuals as one of the most effective conveyors of HIV/AIDS prevention. If significant new technologies become available these will be considered and incorporated as appropriate.

In addition, although these programs may occur at a regional or country level, a participatory, community based approach is integral to the development and implementation of all programs.

In this context, USAID prevention programs will:

Promote safer sexual behavior through information, education and communication.

USAID's extensive experience with information, education and communication (IEC) initiatives in both health and family planning programs is already being

applied to the prevention of HIV/AIDS. Communication programs not only strengthen and support an individual's ability to adopt healthy, low risk behaviors, but also influence existing social norms, creating a more supportive environment for behavior change. IEC activities that use multiple reinforcing channels of communication, from interpersonal communication to mass media, have been proven to be the most effective. Focussing efforts with specific groups, e.g. sexually active young men, for selective communication campaigns is also a proven strategy. In order to reach vulnerable women, every opportunity should be explored to incorporate primary prevention messages into family planning and other health services. The inclusion of HIV positive individuals as HIV prevention educators has been proven as an effective means of HIV/AIDS prevention. In addition, sustained behavior change occurs when not only are knowledge and skills conveyed but perceptions of personal risk are increased. In some circumstances confidential, voluntary HIV testing combined with counseling may assist in the achievement of a sense of personal vulnerability and in an awareness of current health status, which may in turn result in decreased high-risk behavior.

In order to continually monitor and improve HIV prevention communication activities, it is essential to increase our understanding of sexual behaviors, especially as they are influenced by community and culture. Behavioral research and surveys will contribute to further target, refine, and evaluate prevention activities.

Increase the demand for, access to and use of condoms.

Correct and consistent condom use is considered nearly 100 percent effective in preventing HIV infection. Although condom use has risen sharply, the percent of users in at-risk populations is still unacceptably low. USAID has extensive experience with condom promotion in family planning programs and works through existing channels to expand commodity demand and use for STI/HIV prevention.

With the spread of HIV/AIDS, many countries have experienced a rapid increase in the demand for condoms. Dramatic increases in funding will be required to finance projected condom supplies needed for both public and private sector programs. USAID will work with host countries, other donors, and the private sector to estimate future requirements, monitor in-country supplies, and help mobilize the additional resources required to finance these commodities.

Control STIs by improving STI diagnosis and treatment services and by education of persons with STIs.

The goal of STI prevention and control activities is to improve the quality of diagnosis and treatment of STIs, to increase access and use of STI services, and to provide targeted education to STI patients in order to decrease recurrent infections. USAID efforts in this area focus on behavior change among clients with STIs, and on improving STI diagnosis and service delivery.

Interventions related to behavior change for STI clients include: counseling for risk reduction (including partner reduction); promoting correct condom use; encouraging compliance with medical prescriptions; and notifying and treating sexual partners. Communication initiatives will foster individual and community recognition of and demand for STI services. Community participation in planning for these services will be encouraged.

Improved diagnosis and service delivery initiatives include: training care providers in symptom recognition and syndromic management; establishing STI screening and management capability at sites where women seek health services, such as family planning and pregnancy care sites; and strengthening STI case management in those groups whose behavior puts them at highest risk of infection. STI service delivery sites are also ideal locations to assess STI prevalence and incidence, information which serves as a dynamic indicator as to both the risk of the spread of HIV in a community the effectiveness of a program.

A critical issue in STI case management is the availability of effective drugs. USAID programs may work to facilitate this aspect of STI control, including, in some instances, procuring drugs. Should this be required, it will be undertaken with attention paid to the long term financial and programmatic implications and with emphasis on sustainability.

B. Policy reform addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other STIs.

Supportive policies that create an environment in which prevention and AIDS mitigation programs can function efficiently and effectively are critical . Funding levels, the commitment of resources, and priority setting are all policy issues very relevant to HIV/AIDS. Enlightened policies can contribute to mitigating the impact of the disease on both communities and individuals. For example, the protection of the human rights of HIV positive individuals will improve prevention efforts. USAID supports policy dialogue and reform at an international, country and local level and in both the public and private

sectors.

Key areas of intervention for USAID include:

Policy dialogue with decision makers to encourage a high-level, multi-sectoral, coordinated response to HIV/AIDS.

Policies that support international and regional, multi-sectoral approaches will be promoted because of the transnational nature of the disease and the fact that it is transmitted by persons who have no visible sign of the virus. This requires the mobilization of groups that may not normally be implicated in health issues, or may not normally work in collaboration. It also requires cross-border collaboration.

At the country level, key ministries, such as Education, Agriculture, Planning, Defense, Finance, and Health will be consulted concerning the impact of HIV in order to explore with them all possible opportunities for HIV prevention. Provincial, municipal and community level governments must be included in this effort.

The expertise and influence of the private sector will be mobilized as an extremely valuable means to achieve effective and comprehensive responses to HIV/AIDS prevention efforts. Relationships will be forged between the public and private sectors to take advantage of the relative strengths of each in providing a strong and enduring basis from which to address broad public understanding for and acceptance of HIV/AIDS prevention programs.

Policy dialogue to address resource issues and long term sustainability at all levels.

At the international level, coordinating effective donor response and leveraging of funding over the long term is needed to assure that adequate resources will be available for programs to reduce the spread of HIV/AIDS. At the country level, identifying and mobilizing local resources along with institution and systems building are key to long term self-sufficiency of programs.

Examples of resource issues to be addressed include creating a positive regulatory environment for the private sector by dealing with problems such as tariffs and taxes for condoms, government acceptance of social marketing, and procurement of antibiotics and other STI and HIV associated drugs.

Equally, governments need to be educated as to the economic and development ramifications of HIV/AIDS and the cost-effectiveness of devoting resources to activities that prevent HIV/AIDS transmission and mitigate the impact of the disease.

Policy dialogue and reform to address the social and cultural impediments to the successful implementation of HIV/AIDS programs.

As has been previously highlighted, HIV/AIDS prevention touches upon the most sensitive social and cultural mores, those related to sexuality. Human rights, advocacy, empowerment and choice are all issues critical to the development and implementation of sustainable HIV/AIDS programs and policies. Notable examples include the role and status of women and the vulnerability of children and young adults. Confidentiality as well as the rights, treatment of, and status of persons living with AIDS affect all aspects of HIV/AIDS prevention and care.

Support of decision-makers at an international, national, or community level to address difficult social, cultural and religious issues have the potential to contribute to an environment in which persons can begin to make the changes required to prevent transmission of the disease and live with dignity if they are infected.

Develop tools and complete research to serve policy dialogue and reform.

To heighten the awareness of key policy-makers as well as bring about policy change, USAID will continue to develop and use tools that project and simulate the epidemic and assess the potential socio-economic impact. Modelling provides powerful arguments for policy makers and assists leaders and managers to define and prioritize interventions. Models that project, over time, the number of newly infected persons with HIV, the number of AIDS cases, and the potential impact of the epidemic on various sectors of the society are particularly potent. Simulation modelling is also a critical design and evaluation tool, allowing assessment of the impact of different interventions at varying degrees of efficacy.

C. Development and testing of new interventions and methods to prevent transmission and mitigate the impact of the epidemic.

The Agency's HIV/AIDS program priority is to seek the most cost effective means of implementing proven prevention interventions. In addition, USAID will continue to seek new more effective interventions to prevent transmission of HIV, and to mitigate the impact of the epidemic. The following illustrative list describes some of the most promising leads.

Research activities that immediately and directly influence the effectiveness of existing programs.

These activities can be accomplished in a relatively short time-frame and have immediate effect on programs. Thus, priority is given to studies that improve understanding of the behaviors and epidemiology that are principally responsible for transmission of HIV infection. This includes research activities to identify more effective ways to change behavior. Examples include evaluating the role that HIV counselling and testing may play in modifying sexual behavior, the impact of perceived social norms upon individual behaviors, and assessing the impact of including HIV positive individuals in prevention programs. This type of research also contributes to identifying the most cost-effective mix of strategies for preventing sexual transmission of HIV.

Activities that enable women to reduce the risk of HIV infection.

The development of female controlled barrier methods, such as vaginal microbicide, and rapid, simple STI diagnostics, are potentially valuable tools to reduce the risk of HIV and other STIs in women. Research also focuses on enhancing women's access to information for primary HIV/STI prevention, as well as to STI services. Using existing family planning and maternal/child health centers is one approach along these lines. Behavioral research to identify interventions to enable and empower women to assess personal risk and negotiate sexual relationships is also essential.

Pilot projects and research to mitigate the impact of HIV in severely affected areas.

Operations research to test interventions to mitigate the impact of HIV/AIDS on communities, from both a social and cost perspective, are needed to guide program design and policy dialogue. Examples of such pilots include community-based care for persons with HIV infection and AIDS and for AIDS orphans. Tuberculosis, because of its potential secondary public health impact as a predominant HIV related disease, is another topic for further investigation, including analysis of the technical and financial feasibility of short course drug therapy regimens.

Activities that support the public health infrastructure and utilization of HIV vaccines.

Multiple US government organizations and private enterprises are involved in

research to identify and develop an effective HIV/AIDS vaccine. Consequently, USAID's efforts in this area are currently expected to be relatively small, limited to exploring and facilitating opportunities for international field trials of promising vaccines, and coordinating accompanying education and prevention programs.

VI. IMPLEMENTING PARTNERS

USAID's strategy related to HIV/AIDS, as in other priority areas within the Population, Health and Nutrition sector, is based on participatory, collaborative principles. USAID works in partnership with communities, governments, other bilateral and multilateral donors, international agencies and the private and voluntary sector to achieve maximum efficiency, effectiveness and sustainability of programs.

The Agency's HIV/AIDS program will be implemented in support of host-country and Mission strategic objectives and as an integral part of the country strategic plans and action plans. Bilateral activities will receive strong technical support and guidance from USAID/Washington, and will be implemented in close coordination with other donors.

A. Community Participation

Although a community-based, community-owned approach is a component of USAID sustainable development strategies, it is particularly relevant to HIV/AIDS prevention and is an integral strategic focus of USAID's HIV/AIDS strategy. Sustained behavior change is achieved when individual motivation is supported in a community context. USAID supports the Paris Summit Initiative: the Greater Involvement of Persons Infected and Affected by HIV/AIDS (GIPA). GIPA calls for the participation of communities and groups (including persons infected and affected by HIV/AIDS, women and young adults) in the design, management and evaluation of programs and policies. USAID supports this approach which empowers individuals and communities to assume "ownership," thus assuring that programs are relevant and responsive, that indigenous capacities are developed, and that long term sustainability is addressed.

USAID will prioritize funding to indigenous NGOs that exhibit technical and financial capacity. When community groups such as women's groups, local PVOs and NGOs, however, have limited institutional experience in planning, implementing, and financially monitoring activities, USAID will seek to transfer these skills to indigenous groups and encourage and facilitate linkages between indigenous NGOs and U.S. domestic PVOs, NGOs and ASOs (AIDS Services Organizations). USAID recognizes the unique role U.S. based organizations play in combatting the HIV/AIDS pandemic and will encourage their continued involvement.

B. Country Programs

Reducing HIV/AIDS transmission in a time of serious resource limitations requires that USAID concentrate bilateral and core resources on a limited number of emphasis countries while maintaining more modest programs in others. In emphasis countries, USAID will work with host country governments, the private sector, and the NGO/PVO community, within the framework of a comprehensive program, using the multiple channels and approaches delineated in this document. Determination of emphasis countries is founded on epidemiologic, demographic and social indicators that identify:

* Countries that are key contributors to the global epidemic;

* Countries that play a major role in transmission of HIV throughout their geographic region;

* Countries with high HIV prevalence.

Other factors to be considered in the determination of priority countries and resultant program levels include evidence of national commitment and an absorptive capacity within the public and private/NGO sectors, potential for long-term operational sustainability, role of other donors and opportunities to leverage other resources, and Mission support for funding and staff to facilitate and implement HIV/AIDS interventions.

The current list of emphasis countries is found in Appendix II. USAID will work in non-emphasis countries, using primarily bilateral and field support funds, on a more limited scale.

C. Regional Programs/Areas of Affinity

"Areas of affinity" is the concept that clusters of countries may share characteristics that affect the spread of HIV and positively or negatively influence prevention efforts. These characteristics can include, but are not limited to, religious, cultural, political, or demographic attributes. Approaches that address issues within this context may be very effective with a broader reach than country programs. They also encourage and support inter-regional collaboration and are an efficient use of resources.

USAID will explore opportunities to support trans-national and regional activities in prevention and research. Examples include analysis of the impact on HIV/STI transmission of cross border migration, monitoring of STI drug resistance, and the shared development and use of educational approaches and materials.

D. Coordinated multi-lateral and donor community response

Global cooperation and coordination within the donor and lender community is critical to the effective and efficient use of HIV/AIDS resources for significant impact on the disease. Donor coordination is of particular importance to USAID, as the lead donor in this field and the major contributor to multilateral efforts.

USAID will continue to collaborate with and directly support the efforts of the UN multilateral organizations including WHO, UNDP, UNICEF, and UNFPA in HIV/AIDS prevention. Each of these organizations offers unique strengths and skills that contribute to the control of the global epidemic. The efforts of these agencies and the World Bank will now be further optimized through the new UNAIDS Programme. In the future, USAID support to multilateral efforts in HIV/AIDS prevention is expected to occur through UNAIDS. USAID also collaborates closely with Japan in several countries through the US-Japan Common Agenda for HIV/AIDS prevention. (See Appendix III for further discussion of coordination with other donors and federal agencies.)

VII. RESULTS

Monitoring and evaluation is critical to ensuring that USAID resources are used effectively and that they achieve results. ***The guiding principle of evaluation in this area is to reach the objective that no person should be subjected to the risk of disease as a result of responsible sexual activity***. While this is an ideal, progress toward this target will be effected by the collection and use of data to assess progress, refine implementation and demonstrate achievement.

Measuring success in the area of HIV/AIDS requires the use of interim markers and indicators. This is due to the epidemiologic dynamics of HIV transmission and the existence of a long term HIV "carrier" state. Even in the presence of extremely effective prevention interventions, decreases of HIV prevalence may not be measurable for at least 5 to 15 years at a national level. Reduction in STI prevalence, however, is an excellent proxy indicator for effectiveness of prevention activities and can be evaluated in a time frame of 3-5 years. Consequently this program relies on an approach that distinguishes between the short (program process), medium (program outcome), and long (program impact) term.

USAID, in collaboration with WHO, has established a standardized set of global

prevention indicators to be used by both national HIV/AIDS control programs and the donor community. These indicators measure:

- o Knowledge of preventive practices by the target audience;
- o Condom availability;
- o Use of condoms in relationships of risk;
- o Proportion of the population who report "non-regular" sex partners;
- o Quality of STI case management;
- o Prevalence of specific STIs;
- o Prevalence of HIV.

A list of the WHO country program indicators is contained in Annex IV.

With the increased emphasis on integrating HIV/STI prevention and management interventions into family planning and other health care settings, new indicators for evaluation are being developed by the Center for Population, Health and Nutrition within the Global Bureau. These encompass assessing the degree of integration, quality, and utilization of these services. Evaluating a woman's ability to negotiate for safer sex must involve determining the transfer of knowledge and skills, and whether dialogue on sexual matters can occur within a relationship. Measuring outcome should include the increased level of "safer sex" in both casual and conjugal relationships, including assessing dual contraceptive method use and delaying the age of onset of sexual activity.

There is a growing acceptance of the need for qualitative data; the use of mathematical modeling to examine trends and patterns; and the use of multiple evaluation strategies to make evaluation findings more credible.

As part of the recent "re-engineering" effort at USAID, strategic objectives and refined indicators of progress are being finalized. These indicators incorporate and build on the core prevention and reproductive health indicators mentioned above.

APPENDIX I. MODES OF HIV TRANSMISSION

Sexual transmission is well-established as the dominant mode of HIV transmission, accounting for almost 85% of all adult HIV infections worldwide. The proportion of transmission via heterosexual or homosexual relations varies depending on the country; however heterosexual transmission is becoming increasingly important and now accounts for 75 to 80% of sexually transmitted HIV. The other principal modes accounting for the remaining non-sexually transmitted 15% are: mother to child transmission (including breastfeeding); and blood-borne, including transmission related to blood transfusions, injectable drug-use, and contaminated medical and other skin piercing equipment.

Estimates prepared by the WHO indicate that the number of children worldwide who acquire HIV from an infected mother in utero or during the birth process is expected to continue rising through the 1990s because of increases in HIV among women of child-bearing age. Studies have shown that roughly one-third of babies born to HIV-infected mothers in developing countries become infected themselves. Most of this mother-to-infant transmission occurs during pregnancy and delivery. Preliminary data from Kenya and Rwanda indicate that up to 15% of transmission may be attributable to breastfeeding. The risk of HIV transmission through breastfeeding is greater among women who become infected during the breastfeeding period. The international medical community is now urgently engaged in undertaking further research to better define the efficiency of HIV transmission during breastfeeding and to provide breastfeeding guidelines for HIV-infected mothers.

Transmission through blood transfusion is far less significant than through sexual transmission, and has been virtually eliminated in industrialized countries. However it continues to be a mode of transmission in many developing countries. Transmission due to the sharing of needles between injecting drug users is a less prevalent mode of HIV transmission in most developing countries. In parts of Southeast Asia it does, however, account for up to 15% of all adult HIV transmission. HIV transmission through the use of contaminated medical equipment, including reused needles, accounts for a small proportion of all transmission. Also less significant in terms of actual numbers, but nonetheless important, is transmission to health care workers in high HIV prevalence countries due to the lack of gloves and other materials required to practice "universal precautions."

APPENDIX II: 1995 EMPHASIS COUNTRY LIST:

COUNTRIES KEY TO THE GLOBAL EPIDEMIC

Brazil
India
Nigeria

COUNTRIES OF REGIONAL SIGNIFICANCE **

Cote d'Ivoire*
Honduras
Indonesia
Kenya
South Africa
S.E. Asia (Laos, Cambodia, Vietnam)
Thailand*

HIGH PREVALENCE COUNTRIES

Burundi
Ethiopia
Malawi
Rwanda
Tanzania
Uganda
Zambia
Zimbabwe
Dominican Republic
Haiti

* Thailand and Cote d'Ivoire are close-out countries for USAID

** Countries that contribute to the spread of HIV in the region.

APPENDIX III: COORDINATION WITH OTHER DONORS AND FEDERAL AGENCIES

Donor coordination is a fundamental aspect of USAID's operational approach to development. The aim of USAID's donor coordination is to improve its own effectiveness by cooperating with other donors to avoid duplication and promote complementarity.

USAID recognizes that coordination of HIV/AIDS activities and decision-making about such activities is a process, rather than a structure. This process promotes information exchange, builds alliances between different organizations and facilitates the creation of cooperation and programs which are complementary, collaborative and mutually reinforcing.

1. UN System Agencies

Historically, USAID has worked closely with the World Health Organization's Global Programme on AIDS (WHO/GPA) both as a major contributor and as member of a variety of management and decision-making committees including the WHO Global Programme on AIDS Management Committee (GMC), and the GMC Task Force on HIV/AIDS Coordination. In addition, the USG is represented on the Economic Social Council (ECOSOC).

In recent years, as other UN System Agencies have become involved in HIV/AIDS prevention in areas of their comparative advantage, USAID has provided initial support to both UNDP and UNICEF in their respective HIV/AIDS prevention efforts.
In the future, USAID anticipates working with UN System Agencies through the UNAIDS programme which ECOSOC established in July 1994.

Six organizations of the UN system (WHO, UNFPA, World Bank, UNFPA, UNDP, and UNESCO) with differing expertise have joined forces, drawing on their respective experience for the prevention of HIV and mitigation of AIDS on individuals, communities and societies. There are four major components to the UNAIDS program: improved multilateral coordination, support to National AIDS programs, creation of a global forum for international "best practices," and research and development.

With the formation of the UNAIDS programme, USAID anticipates that all U.S. contributions to UN System efforts against HIV/AIDS will be coordinated through UNAIDS. USAID will continue to serve as a member of management and decision-making committees under the new structure of the UNAIDS programme.

2. Other Donors

In addition to USAID's efforts to coordinate at the global level through the UNAIDS programme, USAID works to coordinate programs and activities at the regional, sub-regional and country level. This level of coordination requires communication with a broad group of multi- and bilateral donor organizations.

The U.S.-Japan Common Agenda's HIV/AIDS initiative is one way in which USAID is working to maximize the impact of its assistance through donor coordination. Under the umbrella of the Common Agenda, the Government of Japan has been working closely with USAID to ensure coordinated and complementary programming of GoJ assistance for HIV/AIDS. In addition, through their Grassroots Grants Assistance program, the GoJ is providing complementary support to USAID supported NGOs engaged in HIV/AIDS prevention activities.

3. Federal Agencies

USAID coordinates with other U.S. government agencies through a variety of mechanisms. On a policy level, USAID participates in the USG Interdepartmental Task Force on AIDS which is chaired by the Office of National AIDS Policy.

USAID also plays an active role in coordinating the HIV-related activities of other U.S. government agencies in developing countries, including the Department of Health and Human Services and the Department of State. USAID utilizes Participating Agency Service Agreements (PASAs) to provide support for epidemiological and biomedical research conducted by CDC, BUCEN and NIAID. This mechanism helps to foster collaborative relationships with these Agencies, preventing duplication of effort and facilitating information exchange.

ANNEX IV: WHO/GPA COUNTRY PROGRAM INDICATORS

A. Program Process (1-3 years)

Condom availability:
(Central)

$$\frac{\text{Total No. of condoms available for distribution during the preceding 12 months}}{\text{Population aged 15-49}}$$

(Peripheral)

$$\frac{\text{No. of people who can acquire a condom}}{\text{Population aged 15-49}}$$

B. Program Outcome (3-5 years)

Knowledge of preventive practices:

$$\frac{\text{No. of people citing at least two acceptable ways of protection from HIV infection}}{\text{Total No. of people aged 15-49 surveyed}}$$

Sexual behavior:

$$\frac{\text{No. of people aged 15-49 who report having had at least one sex partner other than a regular sex partner in the last 12 months}}{\text{Total No. of people aged 15-49 who report having been sexually active in the last 12 months.}}$$

$$\frac{\text{No. of people aged 15-49 reporting the use of a condom during the most recent act of sexual intercourse with a non-regular sex partner}}{\text{Total No. of people aged 15-49 reporting sexual intercourse with a non-regular sex partner in the last 12 months}}$$

Quality of STI case management:

$$\frac{\text{No. of individuals presenting with STIs in health facilities assessed and treated in an appropriate way (according to national standards)}}{\text{No. of individuals presenting with STI in health facilities}}$$

$$\frac{\text{No. of individuals presenting with a STI or for STI care in health facilities who received basic advice on condoms and partner notification}}{\text{No. of individuals presenting with a STI or for STI care in health facilities}}$$

STI prevalence and incidence

$$\frac{\text{No. of pregnant women aged 15-24 with positive serology for syphilis}}{\text{Total no. of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened}}$$

$$\frac{\text{No. of reported episodes of urethritis in men aged 15-49 in the last 12 months}}{\text{No. of men aged 15-49 surveyed}}$$

C. Program Impact (5-15 years)

HIV prevalence:
(Under development)

$$\frac{\text{No. of pregnant women aged 15-24 seropositive for HIV}}{\text{Total no. of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened}}$$